MICROCLOTS AND THE BENEFIT OF SPIKE DETOX WITH DR CHETTY VIDEO TRANSCRIPT OF FIRST 38MINUTES OF THE JAN2024 VIDEO

About the Guest(s):
Dr. Philip Macmillan: Dr. Macmillan has been speaking about Covid-19 since early 2020 and has engaged with experts from around the world. He is known for his expertise in the field and has a background in both conventional and functional medicine.
Dr. Robin Rus: Dr. Rus is a double board-certified gastroenterologist and internal medicine physician. She has been practicing conventional medicine for 17 years and has recently transitioned to functional and integrated medicine. Dr. Rus has been actively involved in the study of Covid-19 and long Covid since the beginning of 2020.
Joachim Gerlach: Joachim is the head of research and development at Medicinals, a company focused on developing solutions and protocols to help patients. He works closely with Dr. Robin Rus to develop effective treatments for Covid-19 and its long-term effects.
Shankara Cheddy: Shankara is a general practitioner from South Africa with a background in natural science biology. He has been on the frontline of treating Covid-19 since the start of the pandemic and has been actively involved in understanding the pathophysiology of the disease and vaccine injuries.

[TRANSCRIPT]

0:01:41 - (A): Good afternoon, good morning, wherever you are. I'm Dr. Philip Macmillan. I've been speaking about Covid-19 since early 2020 and I have had the pleasure of speaking with experts across the world. And today is no different. Now, it's not my usual Saturday time because I think we had to tie it all together, but I have three great guests who are going to be focused on the question about microclots and if anyone remembers my recent presentation with the embalmers clots.
0:02:13 - (A): One of the types of clots that they noticed increasing by in 25% of the corpses was that of what they call coffee ground or grainy clots, which were different. And these may fit closest to what our experts are going to be talking about. Myself and Shankara are going to be listening to the presentation. We'll be adding balance and

context and trying to add questions and make sure we clarify the points as we go along.
0:02:43 - (A): So without further ado, I'd like to introduce the guests. I'll just add them in and I'll ask everybody to unmute their mics and we'll start probably with Robin, then Joaquin and then Shankara as the introduction. Do you want to go ahead and give a quick introduction, Robin?
0:03:02 - (B): Sure. Hi. You hear me?
0:03:05 - (C): Yeah.
0:03:06 - (B): Okay. Hi everyone. I'm Dr. Robin Rus. I'm a double board certified gastroenterologist, internal medicine physician. I've been practicing conventional, I mean I practice conventional medicine for about 17 years and I've been practicing functional, integrated medicine for the last four years and I've got sucked into the world of COVID and long Covid since the beginning of 2020. And I've been working with amazing scientists, physicians and researchers all over the globe since then. And the people in my company right now are some of the most amazing people and great mentors and I'm happy to be here.
0:03:49 - (A): Wonderful. Thank you, George. And thank you, Robin. And George.
0:03:53 - (C): Yes. Hello. My name is Joachim Gerlach, I'm from Germany and I'm head of research and development at medicinals and in very close partnership and collaboration, of course, with Dr. Robin Rose, trying to help patients and to develop solutions and protocols that can get the people better.
0:04:10 - (A): Wonderful. And Shankarov.
0:04:14 - (D): Hi Philip. Hi everyone. Can you hear me?
0:04:17 - (A): Oh, yes, we can.
0:04:20 - (D): Yeah. My name is Shankara Cheddy. I'm a general practitioner from South Africa. I'm a natural science biologist. I've been a frontline doctor treating Covid from the start of the pandemic and trying to understand the pathophysiology around the disease that's morphed into treating long Covid and, of course, trying to understand the vaccine injuries. And all the people on the group are bringing a lot of new advances, which I'm eager to try on my.
0:04:43 - (A): Patients and make sure they get excellent, excellent.
0:04:47 - (C): Good.

0:04:48 - (A): So let's get started with an important short video. And before I show it, George, I want you to explain what this video is about so that people watching will understand what they're seeing.
0:05:02 - (C): Yes. That video came out like one and a half years ago. It was a study from the Helmholtz Institute in Munich in Germany. And they did experiments on mice with fluorescent spike protein, which they injected. And also the second part of their study was to look at deceased people and do pathological histopathology and look at the brains in particular, and stain for spike presence. And so this video is quite sobering. And I think it's a good, let's say, intro into our topic today of how to detox spike protein that is stuck in the body, and also by doing that, eliminating microcloths. So if we want to look at that video, I can also maybe comment while it's running.
0:05:56 - (A): Wonderful. So let me play the video now.
0:06:03 - (C): So these are mice that were injected, and you can see the kidney. All organs are very, very strongly affected by spike protein presence in the cells, in the intestines. The same in the intestinal linings, in the ovaries, in the testes. Everywhere you see, there's fluorescent light coming up. That is detection of spike protein. And the worst part, of course, is in the skull, skull, bone marrow, and in the meninges.
0:06:35 - (C): And so to speak, on the periphery of our brain that is all spiked up. And that is, of course, there for a very long time. I just had another paper yesterday, up to 600 days, you can detect either live virus and or spike protein, or spike protein fragments in the human organism. It doesn't go away by itself. And so this paper is like, that was like really a wake up call, because many people think that spike protein is just floating around in the body, in the blood, but it is actually more than 90% or even more than that stuck in the cells.
0:07:17 - (C): And especially in this delicate part of the organism where we speak about during my presentation, you don't want to have that and you want to get it out.
0:07:27 - (A): So just to make sure I got it right, the video was of mice that were vaccinated with which vaccine.
0:07:39 - (C): No, it was not a vaccine. They took recombinant spike protein, like we did also in our own lab. And they put it in fluorescent dye so that it will show up on a scanner.
0:07:50 - (A): And so was it injected intravascularly or was it injected?

0:07:54 - (C): Yeah, it was injected intravenously and we injected it by all means into the tail of animals. We injected it into the subcutaneous knee, how you call that, under the skin? And also intravenously. And it equally distributes through the whole body. We come to that later. And the second part of that video was actually not mice. These were humans. The skull, bone marrow findings and the meninges full of spike is actually findings in pathological examinations of diseased patients. And they found huge amounts of spike protein and neutrophil activation in the brain periphery. So that is something you don't want to have because that explains a lot of the microclotting and, of course, of all the neurological symptoms.
0:08:43 - (A): Any thoughts, Shankaro?
0:08:45 - (D): Yeah, Philip. It shows the wide distribution of spike and shows its affinity for all the different tissues that are there. So I think we've got a road.
0:08:53 - (A): Ahead in trying to detox what I'm trying to think. So you could have someone who is a detractor looking at this and saying, how is this representative of the general population? Any thoughts, Robin, how accurate is this a representation?
0:09:13 - (B): I mean, again, this is animal models that we're looking at in the first case that Jochem said, but if they did look at it both subcutaneously and intravenously, I mean, they didn't do it intramuscularly like we do for the shots. But that's pretty similar as far as how it distributes within human beings. And you also showed how in the pathological exams of human beings post mortem, the spike protein was still there in the skull meninges, in the skull, bone marrow and the meninges. So that's pretty impressive. That means it's widely being distributed after we're exposed to the spike protein in whichever way.
0:09:55 - (A): Okay, that's important. Okay, you want to take us through some of the slides of the presentation. And what we'll do, Shankara and myself, is as we see questions, we'll kind of interrupt to make sure we get clarification and try and make sure it makes sense for the listeners. So who wants to start with this?
0:10:16 - (C): I will start the first part of the presentation and then give over to Robin because we have structured it that way. That, first of all, I will be describing what we are facing in the science, in the findings, then describe successful strategies, and Robin will then show what happened in her patients and what is her experience by using these dietary supplements in protocols on her patients. And what the outcomes are. So that's how we thought it makes sense.

0:10:46 - (C): So we can start with the first slide and we can go right in there with what we are facing. So yeah, this is our group here. And just to give you an idea, we work also in the german laboratory with Professor Hans Rausch on the development of all these products, so that we can ensure that they do have the necessary bioavailability and the right composition and synergistic effects. It's mostly emulsions we're working with that are highly bioavailable and penetrating into the organs to do the job that we require them to do.
0:11:17 - (C): So if you go on the next slide, you see that we test everything in pre clinical, in vitro laboratories. At the moment we are setting up a new laboratory together with Dr. Kevin McCurn, the neuroscientist in Japan, to work on hamsters and to look at the spike detox protocol and as well as the coagulation cascade and most of all of course, into the neurological symptoms that these hamsters are developing after injection of both recombinant spike protein and mrna vaccines.
0:11:49 - (C): And so that is what we are doing before we even start looking into humans. So that is the usual way we work. On the next slide, you see then what we did last year in the summer. So proof of concept, we wanted to see how does bike protein distribute. So this is our own trials. And you can see the animal was after injecting it into the table. In that case, after 72 hours, the spike was spread all over into the complete organism.
0:12:19 - (C): So we can only confirm what the Helmutz Institute did. It is actually really happening in front of our eyes if we try that.
0:12:28 - (A): One question here, George, as I look at this here. So again, I'm trying to understand. So what was injected was the protein.
0:12:40 - (C): The spike protein, the recombinant spike, and it was mixed with a fluorescent dye so that it would show up on a special scanner and we can then see the distribution. And we did tests also without, we did several tests just with a dye, just with a spike, unmarked, and it didn't show anything. So it was a proof of concept. Can we detect spike distribution in the organism? And it worked well.
0:13:09 - (A): Any thoughts, Shankara? Do you think that the fact that they're using spike protein here, because one of the things we're questioning is, is that a representative replication as to what we're likely to be seeing in terms of vaccines and potential vaccine injury? Any thoughts, Shankara?

0:13:33 - (D): I think it is, Philip. Yes, we might get variations in the spike itself. But what the animal models are demonstrating is that irrespective of the route of inoculation, we're getting a wide distribution of it. So I would suspect we're getting distribution through blood distribution, through lymphatics. There's a wide variety of mechanisms at play to distribute the spike that diversely. And of course, the worrying thing is it clearly crosses the blood brain barrier and gets into the neurologic tissue in the brain.
0:14:03 - (D): So, yeah, it shows clearly that there is a widespread biodistribution and correlation with pathology. It shows that there is some correlation between the human pathologic findings and the animal models. So, yeah, we can draw inferences from it.
0:14:23 - (A): Okay. All right, let's move along continuing, because.
0:14:28 - (C): Let'S go to the next slide and then have a closer look. This is the study that we derived the video from. So you can see there, their findings are clear in humans. In pathological examinations post mortem, they find enormous amounts of spike in these areas, especially they were looking at the skull, bone marrow, the meninges. And we know also from other studies that the cardiovascular system is full of spike and the endothelial cells, which we come to in a moment. So if you go to the next slide, you see some screenshots from that paper and from the video.
0:15:05 - (C): You see, again, these are areas that are so sensible, and you don't want to have this highly toxic neurotoxic spike protein in that vicinity to the brain. Plus you have a very high amount of neutrophils in the same area, and they are triggered by the spike. And when they meet the spike protein, they are going to dissolve it and create something worse and more toxic than the whole spike itself. And these are the seven epitopes that are embedded in the spike. And once they are liberated, they create this amyloidogenic, prirgic and thrombogenic fibers.
0:15:43 - (C): And that is actually like a binary weapon almost. It's really to be avoided at all costs.
0:15:52 - (A): Just before we move on there, because this is demonstrating in infection, isn't it, what occurs? It could be argued that this is more likely to happen in infection than, for instance, in vaccination. Any thoughts on that, Shankara? Would it be the same?
0:16:13 - (D): I don't think so, Philip. I think infection. We have the added complication of a viral infection, which virus has been shown in many tissues around the body as

well. With vaccination, you'll get the distribution of spike without the viral infection there. I think there's other things that need to be considered with infection itself. If your body is able to overcome it, then you have a very short dose exposure to spike, whereas with the vaccines, you might not have the virus present, but you got a long exposure to production of spike protein. So the mechanisms might be at play. But I think the way they play out in the different individuals is going to be a little different.
0:16:55 - (A): Yeah, I think I was just trying to. Again, I'm making sure that I bounce the questions that others would ask, which is that they would probably argue that infection in this, certainly in the post mortem, may represent a higher risk because we know that this occurs in terms of the accumulation in the skull. But we don't yet have any studies that demonstrates clearly this occurs in vaccination. We are presuming it.
0:17:23 - (A): I suspect nobody has yet done that.
0:17:25 - (C): Kind of research, but we get to that. It has been done. Anna Burkhard has done that in Germany, and there's plenty of publications. Look, if we want to go in all these details, we would need probably somewhere like 20 hours. So I just took some representative papers here. It's over and over and over been proven now that the spike protein from the vaccine is causing as much damage as the spike protein from infection.
0:17:54 - (C): We come to that we have three perpetrators. It's the virus itself. It's the spike that is being shed off the virus when it is in the process of endocytosis. So you'll have a lot of spike also during infection, and then you have the spike protein that is being repeatedly and persistently produced by transfected cells over a very long period of time, as we have learned from our dear colleague, Dr. Carla Bronier. So actually, you have spike everywhere, plus you have virus everywhere also. That is another thing.
0:18:26 - (C): We just named this spike detox. But you also have to detox pockets of active, replicable virus in the organism, which also stay there for years, sometimes, reportedly, but. Okay, let's get back to the presentation, otherwise it will take too long. Again. Here you see, what is really worrying is the kidney. The kidney is susceptible to spike damage in a very strong manner because the spike there is causing sensitia. That means when the spike meets the cell membranes, it fuses them together into a cell conglomerate, and these cells become dysfunctional and highly inflammatory. They are secreting cytokines the whole time and they are not being removed.

0:19:13 - (C): The spike protein creates its own no go area, so to speak, in the body, where the immune system doesn't touch it, autophagy doesn't happen, and these cells turn into senescent zombie sensitia conglomerates, especially in the kidney that is why I show this here is because when we start to detox, one of the organs where the detox is being taking place is the kidney and the liver. And so we have to protect these organs, especially if we even want to attempt any detox.
0:19:47 - (C): Let's go to the next slide and we get into the details here that is answering your previous question. So honorable cut could show in pathological examinations that this is a cut through an artery. And you can see everything that is in that ring, that brown ring. This is spike fluorescent antibodies. And it's completely full. All endothelial cells are full of spike, either on the membrane or in the cytoplasm.
0:20:18 - (C): And that is of course in the whole organism. That will include the brain, will include the micro vessels. And there again, it is another problem because we are seeing the neurological symptoms in the long haulers. And it resembles, if you look at the MRI scans, it resembles something like a vascular dementia. Because of the impaired blood flow in the brain and the endothelial inflammation, these cells will become dysfunctional when the spike is in there.
0:20:47 - (C): So if you can imagine your whole endothelium is dysfunctional or a big part of it, then of course they will excrete cytokines. You will have, all the mechanisms will be triggered that cause thrombosis and microclotting, and you have endothelial debris being shed off the glycocalyx is destroyed. And it goes on and on. And this is a very long list, what will happen now in this cascade? So this has to be removed. You cannot leave the spike in these cells under no circumstances.
0:21:18 - (C): If we go to any questions?
0:21:21 - (B): Yeah, I do. So this study was done, this was synthetic spike. So this showed, this is vaccine?
0:21:27 - (C): This is vaccine spike, exactly. To answer the question, if the vaccine spike can spread, I mean, it's logical, you inject the lipid nanoparticles with the mrna and give cells the instruction to transform themselves into spike factories. And they keep going, producing spike ongoing for a very long time. And that spike will then go through the bloodstream. And if you look at the affinity of spike protein, I mean, the spike protein function is to hook up to cells to bring the virus to the cell.

0:22:02 - (C): So how can anybody with a five sense intelligence even assume that spike protein will stay long in the blood? It will go and do what it's supposed to do. It will fuse with cells. So when you're producing spike in the billions, over a long period of time, these spike will spread out through the organism and attach to any kind of cell that they are prone to bind to, like these endothelial cells, for example.
0:22:30 - (A): Okay?
0:22:30 - (C): That's what's happening. And they stay there for a very long time. That's the problem. They don't go out there by themselves. We have to keep them.
0:22:39 - (B): But once that cell becomes transfected with the spike, and the spike is then that cell then eventually becomes the senescent zombie cell. Right, because it can't survive.
0:22:51 - (A): Well, one of the questions would be, I could understand if it was the mrna that got into the cell that then makes the spike. But if the spike itself, which is just a protein, gets into the cell, it shouldn't have the capacity to replicate.
0:23:10 - (C): No, it doesn't replicate.
0:23:11 - (B): It doesn't.
0:23:13 - (A): It just accumulates.
0:23:15 - (C): Yeah, it's enough. One spike protein, if you have one spike protein in the cell, it will turn the internal mechanism completely upside down.
0:23:24 - (B): Right.
0:23:26 - (C): So anything that could degrade it or kick it out or destroy it is blocked. The spike wants to survive. It's a survival mechanism built into these proteins and into the virus that once it's inside the cell, it doesn't want the cell to degrade it or to get rid of it. It's very simple.
0:23:45 - (A): Okay, let's move on.
0:23:48 - (C): So here you see that there are more cells than just the endothelial cells. Mostly the parasites, which are kind of bridging between the endothelium and the space behind the vascular space. And that is like a bridge mechanism from there into the brain, for example, into the parentuma, where you don't want to have virus and or spike protein, and it will persist there for a long time. Just to give you an idea where.
0:24:14 - (A): It all goes, just to clarify to people that this kind of setup with the blood brain barrier is very sophisticated, primarily only occurring in the brain.
0:24:24 - (C): Yes.

0:24:25 - (A): Okay.
0:24:26 - (C): Yeah, we go to the next slide. There you see another big problem that is also in the neurovascular system, and behind it is the astrocytes. And the astrocytes are responsible on both sides of the equation. They are on the endothelial side. They are guardians of the blood brain barrier. And so when they get hit by spike protein or by virus, the blood brain barrier is breaking up. So that means all toxins and inflammatory cytokines and whatever can go into the brain. And on the other side of the brain, we have a system.
0:25:05 - (C): We get to that in a second. It's called the glymphatic system. And that system is responsible for flushing our brain while we sleep and to get rid of toxins that build up. And that system is completely blocked during post Covid or post vac conditions. So we shouldn't be surprised that we see the cascade of neurodegenerative disease being accelerated in these patients. Because it's like all your wastewater systems in your house. I block them all, but I keep everything running, the shower and all the sinks. Sooner or later, you'll have an overflow. And that's what happens in the brain because of this. What we see here.
0:25:46 - (A): Okay, next question here.
0:25:49 - (C): Yeah. That has been reported here that we can skip over that quickly. It's the glymphatic system and brain fog. That's a schematic illustration of the glymphatic system between the arteries and the veins and the lymphatic system. So that needs to be restarted also when you want to go and start to detox spike from the brain periphery or from the brain itself. Because if you want to get it out there.
0:26:14 - (C): How can you get it out if your glymphatic system isn't working? That's why it's important for spike detox to understand. Yeah, but we can go further then here. And then if you go one more slide. These are also pathological examinations of brains, and that is what we see. Then on the left side, you see a control brain sample. In the second from the left is an Alzheimer's brain sample. Very strong mycoglyosis, brain inflammation and aggregates.
0:26:42 - (C): And then you see on the second from the right is a SARS CoV two. Infected brain looks almost as bad as an Alzheimer's brain. And on the right, you see an Alzheimer's patient that got infected with SARS CoV two, which then turns out to be a complete disaster. Just to give you an idea, what is the consequence of the presence of the spike in the brain periphery? Next slide, please. That's a different presentation.

We can do it one day. I call this the pressure cooker. That means the complete brain periphery is blocked up, inflamed, open on one hand and closed on the other, creating, like, an environment that you don't want to have in your brain, because it is activating everything you don't want to have at the same time.
0:27:37 - (C): And on the next slide, you see then what happens once the pressure cooker is fully in motion, then you start to see, that is, let's say that the second phase of neurocovid is when you see then the real neurodegenerative severe disease developments. Aggregation of amyloid beta of alpha syndrome, Lewy bodies, you have microglyosis, brain inflammation, ferptosis and all these mechanisms that you don't want to have, and it's all a result of the presence of the spike causing all that and or the virus sometimes, of course.
0:28:12 - (A): Can I make a point here? Is that one of the things that, in terms of dementia, it's been one of my pet topics for many, many years before COVID And based on what we're seeing, both with infection and the spike protein from any other source, it was already a pandemic. It was already globally doubling numbers every 20 years. At the rate it has gone with the pandemic, we could be seeing doubling, maybe even every five to ten years.
0:28:48 - (A): This is at a scale that I cannot explain how serious it is. And once it starts to be realized, meaning that the damage has been done and people start to have symptoms, it is absolutely too late before we move on. Any thoughts, Shankara?
0:29:04 - (D): Absolutely, Philip. We see, I'm seeing it in my practice, the neurologic issues that are coming from the vaccine itself. And I don't think people realize it just yet. Like you said, it's going to take a little while for it to show up clinically, and then the statistics are going to show the immensity of what we're actually dealing with. There's a big lag that's giving us a false sense of security.
0:29:28 - (C): Yeah. Okay, let's continue, otherwise we'll never finish.
0:29:32 - (A): Yes, that's what I said. So jump through because we want to hear some of Robin's experience.
0:29:38 - (C): I'll go very quick. So this is a video. I took some screenshots of the senescent cell formation, which I mentioned before. Cell conglomerates being built. And these harbor a lot of free spike and or virus. So these are the areas we want to knock out for sure. That's where most of the spike is hiding. If we go to the next slide,

you see also that the immune cells are full of spike and or virus. That's another big problem. How do we get them out?
0:30:04 - (C): Because your monocytes, macrophages, CD four T helper cells and other immune cells of our own immune system are filled with coronavirus and or spike protein. How can they properly function? That's why we do see some, to some degree now. A very strong immunodeficiency in the general population. But another topic. So let's go to the next slide and look at what we are facing. So the task is actually we have two kinds of cells. One I would call the productive cells. That means they have either mrna from the vaccine inside and produce spike because of that. And they don't stop.
0:30:45 - (C): Or you have cells that are still infected with SARS, cov two, and they produce new virus and of course also spike protein. And then you have the second type of cells which are called deposed cells. That means these are cells that are just harboring nonproductive spike protein, but nonetheless are highly inflammatory and it doesn't go away. So that is what we have to take care of in our, let's say, protocols. That's what we're facing, that's the task.
0:31:15 - (C): So let's go to the next slide and have a look how it looks in the vaccine. Injured people. On the left side you see a lipid nanoparticle containing mrna that is transfecting cells, converting them into spike factories. And they are excreting three different kinds of products, so to speak. Either just spike protein alone, spike protein in extracellular vesicles, or mrna in extracellular vesicles, which will then go to other cells and do what we don't want them to do.
0:31:48 - (C): So that is what we are targeting. I don't want to go into much more detail because of the time today.
0:31:52 - (A): Let's go a second there, George. I think that that is probably my biggest concern, is that when I look at the long Covid, the long haul picture, I've always worried that what we're dealing with is not necessarily active infection in people six months, a year down the line, but long term ability of cells to produce spike protein on and on and on, with no real way to try and get rid of it. I think that's the big challenge. And when I look at that picture there, that just highlights to me. Once some of these cells, especially if it happens in an immune cell that can live a whole lifetime, we have a real problem with getting rid of these lipid nanoparticles, which can then spread to other cells via extracellular vesicles.

0:32:51 - (C): Yes, I mean, in principle, everything is doable. We are still lacking some data. We are very far ahead of the curve anyhow, globally. But we need now these animal trials with examination of the tissue, to see if we can really get rid of every aspect of this ongoing disaster. But yes, you're right, it is a concern. But if you have enough load of spike gotten into your cells, even if you don't have any existing production of spike, it's still bad enough, because the cells that were transfected with a spike, even if it's a deposit cell, will not die.
0:33:33 - (C): They become immortal in this senescent process. And so it will stay. We have document now, I didn't include in the slides 650 days of presence of spike protein in senescent cells.
0:33:46 - (A): 650 days?
0:33:49 - (C): Yes, sir.
0:33:50 - (A): That is just almost two years.
0:33:53 - (C): Yeah. If we wait a little bit longer, we find out maybe it's three years or four years. Let's go to the next slide so that we have some time for robin to speak. Let me run you through this. So these are exocellary vesicles containing spike. Another way that especially sensitia formation is sensitia conglomerates are very prone to spit out these exosomes, or exacellibesicles, and they contain, amongst other things, spike protein.
0:34:25 - (C): And these exocellar vesicles are actually like our own lipid nanoparticles that we produce in our own body. They can fuse with any cell, they don't need any receptor, makes it very dangerous. In that case, they can also harbor good things. We are using them as trian horse for our molecules. So it's not only bad, it's just a container that can go through any door, that's all. But we see that a lot. So on the next slide, we want to dodge into. So the first thing that can be done is autophagy.
0:34:58 - (C): Here's a paper looking at, especially autophagy being blocked in Covid-19 pathogenesis and what the molecules we are using can do about it. Because if you want to go the route of autophagy through intermittent fasting and these kind of measures, the virus is prepared for that. And the spike protein, it has blocked successfully most of the autophagy mechanisms. So you want to override them. And this can be done with these molecules. So that's the first way of trying to reduce the number of spike in cells.

0:35:33 - (A): And just to be clear, to make sure everybody understands, you are saying that normally what the virus does is blocks these cells from dying so that they become immortal, infected with either the virus or remnants of the virus, and then continue to produce it. And even fasting, you said, doesn't interfere with that?
0:35:58 - (C): Yeah, because it's been blocked. So the mechanisms you trigger to fasting, we have no real data, but the findings of other papers show that these pathways are blocked successfully. The only chance we have is to try to push from the outside to restore the functioning of these pathways and get these cells into an autophagy process again so they can degrade some of these proteins. Okay, but that is not proven yet. That is a hypothesis, and it seems, but in the overall setting of the patients, it seems to help.
0:36:36 - (C): We're doing. So this is what I say. It's just like one of the many ways how you can get rid of spike would be an approach in this direction. But let's go to the parts that we really know they work. Let's go to the next slide, please.
0:36:51 - (A): Yeah, next one beyond this one.
0:36:53 - (C): Yes. There we go. So if you have cells that are in a senescence state, there is now enough evidence in vivo on SARS CoV, two senescent cells that senolytics can really make a big difference, and they break up these cells. So we have created now senolytic, let's say, compounds that are helping medicinals, which by itself is a strong synolytic because quercetin is in there in high amounts through a votabolization process in a very pure form in the serum.
0:37:27 - (C): So we are helping medicinals with this other product here and breaking up the cells, be it sensitia and or single cells harboring spike and or virus. And by doing so, we get these cells removed, because, anyhow, they are a very high, they excrete a lot of cytokines, and so you want to remove them anyhow. It's a very common antiaging method also to take out these senescent cells in elderly to fight the aging process.
0:38:03 - (C): So that is a very safe and proven thing to do. The only problem is, if we look at it now, if you start to move and mobilize virus or even spike protein, it will then go into the bloodstream or into the limb stream, and then it is prone to just go to the next cell and destroy that in an instant. So we have to make sure that this is being done in a very controlled manner. Everything has to fit, molecular size, biodiversity, availability, the presence in the serum, the half life and the ability to chelate. So let's

go to the next slide, and I guide you through the whole thing. So these are all SARS CoV, two documented senescent and sensitia cells on the next light as well.
0:38:55 - (C): We can later give out this presentation. So it's over and over documented that the spike protein and or the virus is very much present exactly in these cell conglomerates.